MAR 25 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

4713

File No. .....

Registered No. .....

1. PLACE OF DEATH

County Green

Township Washington

City ~~Rogersville Mo~~ R.R. (No. ..... St. ..... Ward)

Registration District No. 321

Primary Registration District No. 5445

2. FULL NAME James Edward Jessup

(a) Residence, No. ..... St. ..... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 14" 1923

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
6	5	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Frank Jessup

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Anna Beatie

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

14. INFORMANT Frank Jessup
(Address) Rogersville Mo. R.R.

15. FILED 2/14 1930 W L Turner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 13th 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 22, 1929 to Feb 11th, 1930 that I last saw him alive on Feb. 11th, 1930, and that death occurred, on the date stated above, at 3 O'clock a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lympho-Sarcoma

535

1113 (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Pulmonary Edema (duration) ..... yrs. ..... mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Home

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory

(Signed) N. S. Burke, M. D.

2/14, 1930 (Address) 214 N. Jefferson St. Springfield Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hazelwood, Cemetery

DATE OF BURIAL Feb. 16th 1930

20. UNDERTAKER T. B. Chaffin

ADDRESS Ozark, Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County: Greene — Registration District No.: 321 — File No.:
Township: Washington — Primary Registration District No.: 3443 — Registered No.: 7
City: ..... (No. ....., ... St. ..... Ward)

2. FULL NAME: James Edward Fessler
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED: 2/18, 30 — W. L. Turner, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 13 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19..., that I last saw h... alive on ....., 19..., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myxoglio-Sarcoma
Diffuse type - primary in
Spleen
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY): Pulmonary Edema
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ....., M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

Y, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1930 - 1 - 8
65 - 0 - 25

64 - 12 - 13

S-4713